STATEMENT OF FACTS FOR AN ADDITIONAL PERSON

(*Supplemental Application for Food Stamps and Request for Cash Aid*)

INSTRUCTIONS: Fill out this form to tell us about a new person in the home. If you need more space to answer the questions, attach another sheet of paper. Fill in the answers for all the questions about the benefits you are asking for. The "CA" for cash aid and "FS" 'for food stamps listed to the left side of each question tell you which questions are for which program.

If you get cash aid, and you want aid for the new person, this form must be filled out by either the adult caretaker relative who is now getting cash aid or the new person, unless the new person is a child.

For Food Stamp households, which do not get cash aid or do not want cash aid for the new person, this form may be completed by a household member, an authorized representative or the new person.

PLEASE PRINT IN INK

COUNTY USE ONLY

CASE NAME

CASE NUMBER

WORKER NAME

WORKER NUMBER

DATE RECEIVED

VERIFIED:	YES	NO
SSN		
FS ID		
Blind/Deaf/Disabled		
Residency		
DFA 285-C Comp.		
Referred to Cal-Learn		
CA 25 Completed		
CA 25 A Completed		
Referred to GAIN		
Citizen		
Eligible Non-citizen		
Sponsored		
SAVE		

Date of Entry to U.S._____

Excluded HH Member Code _____

Work/Training/GAIN Code _____

CA FS (1) Name of Person Completing Form (First, Middle, Last)

CA FS (2) List new person in the home, including a newborn.

NAME (First Middle Last)

CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. Citizen/National

☐ Noncitizen: Sponsored ☐ YES ☐ NO

SOCIAL SECURITY NUMBER - -

BIRTHDATE - -

PREGNANT ☐ YES ☐ NO

IS HE/SHE A PARENT? ☐ YES ☐ NO

BIRTHPLACE (City/State/Country)

SEX (✓) ☐ M ☐ F

SCHOOL STATUS (✓)

☐ Has a High School Diploma

☐ Has a GED

☐ Currently Attending School

☐ Not Attending School (Explain):

MARITAL STATUS

☐ Married ☐ Never Married ☐ Separated

☐ Divorced ☐ Common Law ☐ Widowed

BLIND/DEAF/DISABLED ☐ YES ☐ NO

RELATED TO APPLICANT/CARETAKER/HEAD OF HOUSEHOLD?
If "YES", explain relationship: ☐ YES ☐ NO

ANY OTHER NAME USED, BELOW: (Maiden, adoptive, etc.)

CA FS (3) Has he/she applied for or received benefits in the past, such as: cash aid, food stamps homeless assistance, Medi-Cal, Refugee Cash Assistance? ☐ YES ☐ NO
If "YES", explain:

WHEN	WHERE (County, State, or Country)	TYPE OF BENEFIT

CA (4) Is he/she a child under age 19? If "YES", complete below: ☐ YES ☐ NO

MOTHER'S NAME (✔) Lives in Home	FATHER'S NAME (✔) Lives in Home	Reason Other Parent Does Not Live in the Home	Child Needs Aid Due to Parent's (Check all boxes which apply)
			☐ Absence ☐ Unemployment ☐ Incapacity ☐ Death
☐ Yes ☐ No	☐ Yes ☐ No		

VERIFIED: Deprivation ☐ YES ☐ NO

CA FS (5) Has he/she been in the U.S. military service or the spouse, parent or child of a person who has been in the military service? If "YES", explain: ☐ YES ☐ NO

LIST NAME, BRANCH OF SERVICE, ETC.

HONORABLE DISCHARGE ☐ YES ☐ NO

CA 5 ☐ YES ☐ NO

Date Initiated _____

CA (6) Has he/she lived in California for the last 12 months in a row? Complete below: ☐ YES ☐ NO

LAST PLACE OF RESIDENCE (City, State)	DATE ARRIVED IN CALIFORNIA

Apply RFG: ☐ YES ☐ NO

State _____

RFG MAP _____

RFG Months _____

CA (7) Does he/she presently live in California and intend to continue living here? ☐ YES ☐ NO
If "NO", explain:

COUNTY USE ONLY

☐ AFDC and FC Eligible/
CR Chooses:
Child: ☐ AFDC ☐ FC
CR: ☐ AFDC ☐ None

CA FS (8) A. Is he/she a foster child(ren) living in the home? ☐ YES ☐ NO

FS B. Do you want the foster child **and** their foster care income included in the Food Stamp case? ☐ YES ☐ NO

CA FS (9) A. Is he/she 16 or older and enrolled in school, college, or a training program? If "YES", complete below: ☐ YES ☐ NO

VERIFIED:
School Enrollment ☐ Yes ☐ No
FS Eligible Student ☐ Yes ☐ No

NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING?
IF ENROLLED, CHECK (✔) STATUS ☐ Full time ☐ Half time ☐ Other (specify):			☐ YES ☐ NO

CA FS B. Complete below if he/she is enrolled in college or attending a similar educational institution.

TERM	TUITION/FEES PER TERM	BOOKS, EQUIPMENT, ETC., PER TERM
☐ Semester ☐ Year ☐ Quarter	$	$
ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED
TRANSPORTATION COST PER WEEK $	AMOUNT PAID BY CARPOOL MEMBERS $	PUBLIC TRANSPORTATION (BUS, ETC.,) PER DAY $

VERIFIED:
Expenses ☐ Yes ☐ No
Financial Aid ☐ Yes ☐ No

CA FS (10) Has he/she had cash aid or food stamps stopped for a period of time or forever due to: non-cooperation during a quality control review, work or training sanctions, or due to welfare fraud or an Intentional Program Violation? If "YES", complete below: ☐ YES ☐ NO

WHY	WHEN	WHAT COUNTY/STATE

CA FS (11) Is he/she hiding or running from the law for a felony, an attempted felony, or for a parole or probation violation? ☐ YES ☐ NO

FS (12) Does he/she buy food and fix meals separately from others in the home? ☐ YES ☐ NO

Separate household eligible
☐ Yes ☐ No

FS (13) Is he/she age 60 or older and unable to buy food and fix meals separately because of a disability? ☐ YES ☐ NO

Separate household eligible
☐ Yes ☐ No

FS (14) Does he/she pay you for meals and/or a room? ☐ YES ☐ NO

CHECK (✔)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY	Household Elects BOARDER	HH MEMBER	ROOMER
☐Meals ☐ Room ☐ Both	$					

FS (15) Does he/she get food from any of the following programs? ☐ YES ☐ NO

- Communal dining facility for the elderly or disabled
- Food distribution program operated by a Native American reservation
- Other food program

If "YES", complete below:

NAME OF PROGRAM

CA FS (16) Is he/she working now or expecting to be working in the next two months? If "YES", complete below. Attach paystubs or other proof of earnings. (Note: If self-employed, list business expenses on a separate sheet of paper and attach it to this form). ☐ YES ☐ NO

EMPLOYER NAME	SELF EMPLOYED ☐ YES ☐ NO	OCCUPATION	DAYS/HOURS WORKED PER MONTH

PAY DATE(S)	WAGES BEFORE DEDUCTIONS	TIPS OR COMMISSIONS
	$ per	☐ YES Amount $ ☐ NO

COUNTY USE ONLY

(✔) if Exempt
☐ CA
☐ FS Adult
☐ FS Child

FS S/E Farmer ☐ Yes ☐ No

Verification(s) on file: ☐ Yes ☐ No

CA FS (17) A. Does he/she pay someone to care for a child, disabled adult or other dependent so he/she can go to work or training or look for a job? If "YES", complete below: ☐ YES ☐ NO

NAME OF PERSON WHO RECEIVES CARE	NAME OF PERSON WHO GIVES CARE	MONTHLY AMOUNT PAID
		$
		$

Child Care Informing Given to Client:

Trustline Informing (CCP 2)	Health & Safety Certification (CCP 5)
☐ Yes ☐ No	☐ Yes ☐ No

Dependent Care Eligible

CA	FS
☐ Yes ☐ No	☐ Yes ☐ No

CA FS B. Does he/she get child care costs paid for them? Include costs paid by a relative or friend, Department of Education, Student Aid Block Grant, Cal-Learn, TCC, NET, GAIN, SCC, CAAP, etc. If "YES", complete below: ☐ YES ☐ NO

NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID
		$
		$

CA FS (18) Has he/she stopped or refused work or training in the last 60 days? If "YES", complete below: ☐ YES ☐ NO

	YES	NO
Emp. Statement		
Good Cause Determ		
Voluntary Quit		

☐ CA: 30 days

☐ FS: 60 days

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM

Did this person get or expect to get wages or benefits this month? If "YES", complete below. ☐ YES ☐ NO

LAST PAYCHECK RECEIVED (DATE)	AMOUNT BEFOREDEDUCTIONS
	$
EXPECTED CHECK (DATE)	AMOUNT BEFOREDEDUCTIONS
	$

NUMBER OF HOURS OF WORK/TRAINING

Last Month_____

This Month_____

LAST DAY OF WORK/TRAINING	TIPS OR COMMISSIONS
	☐ YES Amount $ ☐ NO

REASON FOR LEAVING JOB/TRAINING

CA FS (19) Is he/she on strike? If "YES", complete below: ☐ YES ☐ NO

Striker Regs Apply

CA	FS
☐ Yes ☐ No	☐ Yes ☐ No

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM

NAME OF UNION

DATE WENT ON STRIKE

GROSS MONTHLY INCOME EARNED FROM THIS JOB BEFORE THE STRIKE

$

CA FS (20) Does he/she pay child or spousal support? If "YES", complete below: ☐ YES ☐ NO

NAME OF CHILD OR SPOUSE	AMOUNT PER MONTH	COURT ORDERED
	$	☐ YES ☐ NO

Court Order on File ☐ Yes ☐ No

Amount Ordered

$

CA FS (21) Has he/she applied for or received any other benefits in the last 12 months, such as: Social Security, Unemployment/Disability Insurance, Cash Aid, Child/Spousal Support, Veterans Benefits, Free Housing, Free Utilities, etc.? If "YES", complete below: ☐ YES ☐ NO

TYPE BENEFIT	AMOUNT	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED	HOW OFTEN (Weekly, Monthly,Etc.)	DATE EXPECTED TO START AND STOP	(✓) if Exempt CA	(✓) if Exempt FS
		$				START:		
						STOP:		

CA (22) FS Does he/she own or is he/she buying any real estate, such as land and/or buildings anywhere, including outside the U.S.? ☐ YES ☐ NO

If "YES", complete below:

TYPE (LAND, HOUSE, APARTMENT, ETC.)	USE (HOME, RENTAL, ETC.)	ADDRESS OR LOCATION	ESTIMATED VALUE	AMOUNT OWED
			$	$

COUNTY USE ONLY

Home Exempt ☐ Yes ☐ No

Other Real Property

Market Value $_____

Amount Owed $_____

Net Value $_____

Lien Applicable ☐ Yes ☐ No

CA (23) FS A. Does he/she have any of the following resources? ☐ YES ☐ NO

If "YES" check (✓) each item and explain below:

RESOURCE	YES	NO	RESOURCE	YES	NO
Checks or Money (at home or elsewhere)			Trust Funds		
Checking/Savings/Credit Union Account			Stocks, Bonds, Certificates, IRAs, Retirement Funds		
Notes, Mortgages, Trust Deeds, Sales Contracts			Other (list below)		

TYPE OF RESOURCE	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE	(✓) if Exempt AFDC	(✓) if Exempt FS
				$		
				$		

CA FS B. Does he/she get income from any of these resources, such as interest, dividends, etc.? ☐ YES ☐ NO

If "YES," list each item and explain below:

SOURCE OF MONEY	HOW MUCH	HOW OFTEN
	$	
	$	

CA (24) FS Does he/she own, lease, or use any motor vehicles, such as a car, truck, boat, trailer, van, mobile home, off-road vehicle (ATVs), motorcycle, seadoos, jetskis, etc.? ☐ YES ☐ NO

If "YES", complete below:

NAME OF OWNER IF LEASED CHECK (✓)	HOW USED	YEAR, MAKE, MODEL	LICENSE NUMBER & STATE OF REGISTRATION	LICENSED (✓)	ESTIMATED VALUE	BALANCE OWED
☐ Leased				☐ Yes ☐ No	$	$

(✓) If Exempt Leased — Vehicle Valuation

☐ Exempt

☐ Leased

CA (25) FS Does he/she own or use <u>personal property</u> which cost at least $100 for each item or is now worth at least $100 each, such as: jewelry, equipment, instruments, livestock, etc.? Do **no**t list clothing, wedding rings, rugs, furniture, appliances, or other household furnishings. ☐ YES ☐ NO

If "YES", complete below:

OWNER	NAME OF ITEM	DATE BOUGHT	PURCHASE PRICE OR CURRENT VALUE	BALANCE OWED
			$	$
			$	$

☐ Owned Jointly

☐ Owned Separately

Net Market Value

$ _____

CA (26) FS Has he/she sold, transferred or given away any real or personal property within the last 2 years for cash aid and within the last 3 months for food stamps? ☐ YES ☐ NO

If "YES", explain below:

Closed Bank Accounts:

☐ Food Stamps in last 3 months

CA (27) FS Does he/she have any of the following insurance coverage: life, burial, disability or mortgage? ☐ YES ☐ NO

If "YES", complete below:

NAME OF INSURANCE COMPANY	POLICY NUMBER	PREMIUM PAID BY (NAME)	AMOUNT PAID
			$

Total CSV

(1) _____

(2) _____

Total Countable Property:

Items 22-27

AFDC $ _____

FS $ _____

CA (28) FS Does he/she have health or hospitalization insurance, including insurance paid for by an employer or absent parent, such as: Blue Cross, Kaiser, CHAMPUS, Medicare, etc.? ☐ YES ☐ NO

If "YES", complete below:

NAME OF INSURANCE COMPANY	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
		$	

☐ Health Care Options Explanation Given

Referral _____

NA _____

☐ DHS 6155

☐ DFA 285-C

Medicare Gross Premium

$_____

COUNTY USE ONLY

Retro Medi-Cal
Requested ☐ Yes ☐ No
Approved ☐ Yes ☐ No

CA (29) Did he/she get medical/ pregnancy treatment this month or in the three months before this month? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	WAS PAYMENT MADE FOR TREATMENT?		WANT MEDI-CAL FOR THOSE MONTHS?	
		YES	NO	YES	NO

CA (30) Does he/she have any health insurance available from a parent, employer or absent parent, which has not been applied for? ☐ YES ☐ NO
If "YES", complete below:

☐ DHS 6155

NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID
	$	
	$	

CA (31) FS Does he/she have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? ☐ YES ☐ NO
If "YES", complete below:

VERIFIED:
Higher/Lower MAP ☐ Yes ☐ No
Special Need ☐ Yes ☐ No
☐ DFA 285-C

TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY

CA (32) FS A. Does he/she have a medical condition(s) or situation(s) that requires any of the following? Check (✓) each item YES or NO:

	YES	NO		YES	NO
Special diet--prescribed by a doctor			Very high use of utilities		
Special transportation need			Special laundry service		
Special telephone or other equipment			Other (specify):		
Housework (no one in the home can do it)					

If 'YES", explain:

CA Special Need ☐ Yes ☐ No
Amount $_____
VERIFIED:
CA ☐ Yes ☐ No
FS ☐ Yes ☐ No
☐ DFA 285-C

CA FS B. Does he/she get In-Home Supportive Services (IHSS)? ☐ YES ☐ NO
If "YES", how much does he/she pay each month? $_____

☐ DFA 285-C

CA (33) The following services are available. Answers to these questions for yourself or anyone in the family will not affect your eligibility.
Check (✓) each item YES or NO.

	YES	NO
A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention program (CHDP) for eligible members of your family under age 21.		
• Do you want more information about CHDP Services?		
• Do you want CHDP medical services?		
• Do you want CHDP dental services?		
• Do you need help making appointments or with transportation to CHDP Services?		
B. If anyone in the family is pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help?		
C. Is anyone in the family breastfeeding a child?		
If "YES", was the birth within the last 12 months?		
If "YES" checked to (33) B or C, you may be eligible for services provided by the Women, Infants and Children (WIC) Special Supplemental Food Program.		
D. Do you or any family member want free or low-cost family planning services ?		
If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.		

☐ CHDP Brochure and Explanation Given
Date: _____
☐ Referral

☐ Pregnant
☐ Parent or Guardian of child under 5
☐ Breastfeeding
☐ Postpartum
☐ WIC referral

☐ Family Planning Information Given
☐ Referred Date _____

CERTIFICATION

I understand the disqualification and/or welfare fraud penalties I will get if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

I understand that:

- If I do not follow cash aid rules, my cash aid can be stopped for 6 months for the first violation, 12 months for the second, and forever for the third. And I may also be fined up to $5,000 and/or sent to jail/prison for 3 years.
- If I give false or incomplete facts, I may be fined or sent to jail or prison if I am found guilty of committing perjury.
- If I file more than one application for cash aid so I can get cash aid in more than one case at the same time, or give the county false proof for an ineligible child or for a child that does not exist, my cash aid can be stopped for 2 years, 4 years, or forever.
- If I do not follow food stamp rules, my food stamps can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to $250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
  - I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation;
  - I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second;
  - I traded or sold food stamps that were worth $500 or more, my food stamps can be stopped forever;
  - I gave the county false identity or residence information so I can get food stamps in more than one case at the same time, my food stamps can be stopped for 10 years.

I also understand that:

- I must apply for and keep any available health coverage if no cost is involved; if I don't, my Medi-Cal will be denied or stopped.
- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, etc.
- A Social Security Number (SSN) is required by law and will be matched with other records to be sure that I am not getting aid in more than one case, or in another county or state.
- All facts I gave, including benefit and income facts, may be reviewed and checked out by county, state and federal personnel, and that if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps, and full Medi-Cal.
- I or other family members will be required to repay any cash aid I should not have received.
- The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a non-citizen household member or the authorized representative of residents in an eligible institution, may be required to repay any benefits the household should not have received.
- Any member of my household who is hiding or running from the law for a felony or attempted felony, or is in violation of their parole or probation cannot get food stamps.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, ADULT FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMP AUTHORIZED REPRESENTATIVE)	DATE
SIGNATURE (OTHER PARENT IN THE HOME, IF APPLYING FOR CASH AID)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT	DATE

EW SIGNATURE	DATE